Date of Hearing: July 15, 2025

ASSEMBLY COMMITTEE ON JUDICIARY
Ash Kalra, Chair
SB 403 (Blakespear) – As Amended May 1, 2025

SENATE VOTE: 26-6

SUBJECT: END OF LIFE OPTION ACT: SUNSET

KEY ISSUE: SHOULD THE SUNSET ON THE END OF LIFE OPTION ACT BE REPEALED?

SYNOPSIS

*Generally, there is a constitutional right of individuals to refuse medical treatment. The U.S. Supreme Court has recognized that a competent adult has a constitutional right to withdraw or withhold life-sustaining treatment that may cause or hasten death. (*Cruzan v. Director, Missouri Dept. of Health *(1990) 497 U.S. 261.)*

The End of Life Option Act (Act) enacted by ABX2 15 (Eggman, Chap. 1, Stats. 2016, 2nd Ex. Sess.), took effect on June 9, 2016. California modeled the Act after Oregon's medical aid-in-dying law, which has been in effect for more than 20 years. In addition to California, Colorado, Delaware, District of Columbia, Hawai'i, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington have some form of legislation authorizing medical aid in dying (MAiD). According to polling done in 2023 on behalf of Compassion & Choices, the sponsor of this bill, both national and state polling shows that the vast majority of healthcare professionals and voters across the demographic spectrum support MAiD as an end-of-life care option for terminally ill adults to peacefully end unbearable suffering. The polls also show support for MAiD is rising over time. As a result of SB 380 (Eggman), Chap. 542, Stats. 2021, many of the barriers related to a terminally ill patient's right to obtain an aid-in-dying prescription from their physician under the Act, including by removing the requirement that a patient wait 15 days between requests for assistance, were removed. SB 380 at one point proposed to remove the sunset date from the Act, but ultimately it was amended to extend the sunset until January 1, 2031.

This bill recently was approved by the Committee on Health by a vote of 13-2-1. Sponsored by Compassion and Choices Network, it simply (but not without controversy) repeals the January 1, 2031 sunset date for the Act. The bill requires the CA Department of Public Health (DPH), no later than April 1, 2026, to meet with relevant stakeholders to seek input on the inclusion of additional information already available to DPH, in the annual report on the Act. Commencing with the report due July 1, 2026, it would require DPH to include the additional data in the report, based on the stakeholder input received. The bill is supported by numerous organizations supporting end of life choice, seniors, and hospice care. It is opposed by religious organizations and the California Foundation for Independent Living Centers, among others.

SUMMARY: Repeals the January 1, 2031 sunset date for the End of Life Option Act and makes related changes. Specifically, **this bill**:

1) Repeals the January 1, 2031 sunset date for the End of Life Option Act (Act).

2) Requires, by no later than April 1, 2026, the California Department of Public Health (DPH) to meet with relevant stakeholders for the purpose of seeking input on the inclusion of additional information already available to the department pursuant to the reporting requirements in existing law.

3) Requires, commencing with the report due on or before July 1, 2026, and for each report thereafter, the department to include in the report additional data, as determined by the department, based on the input received pursuant to 2).

EXISTING LAW:

1) Establishes the End of Life Options Act (Act), which authorizes a process for terminally ill adults living in California to obtain and self-administer drugs for medical aid-in-dying (MAiD). Defines "terminal disease" as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, result in death within six months. Defines "self-administer" as a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug. Sunsets the Act on January 1, 2031. (Health and Safety Code (HSC) Sections 443–443.22.)

2) Authorizes an individual who is an adult with capacity to make medical decisions and has a terminal disease to make a request to receive a prescription for an aid-in-dying drug if all of the conditions are satisfied:

   a) The individual's attending physician has diagnosed a terminal disease;

   b) The individual has voluntarily requested a prescription for an aid-in-dying drug;

   c) The individual is a resident of California and is able to establish residency, as specified;

   d) The individual documents the request, as specified in 5) below; and,

   e) The individual has the physical and mental ability to self-administer the aid-in-dying drug. (HSC Section 443.2.)

3) Prohibits a person from being considered a "qualified individual" solely because of age or disability. (*Ibid*.)

4) Requires a request to be made solely and directly by the individual diagnosed with the terminal disease, and prohibits the request from being made on behalf of an individual through a power of attorney, an advanced health care directive, a conservator, health care agent, surrogate, any other legally recognized health care decision maker, or other means. (*Ibid*.)

5) Requires an individual seeking to obtain a prescription for an aid-in-dying drug to submit two oral requests, a minimum of 48 hours apart, and a written request to his or her attending physician. Requires the attending physician to directly, and not through a designee, receive a request and ensure the date of a request is documented in an individual's medical record. Prohibits a documented oral request from being disregarded by an attending physician solely because it was received by a prior attending physician or an attending physician who chose not to participate. (HSC Section 443.3.)

6) Requires the written request to be on a prescribed form, signed and dated, by the individual seeking the aid-in-dying drug in the presence of two witnesses who attest that the individual is personally known to them, or has provided proof of identity, voluntarily signed the request in the witnesses presence, is believed to be of sound mind and not under duress, fraud, or undue influence. Prohibits the attending physician, consulting physician, or mental health specialist from being a witness. (*Ibid.*)

7) Requires the attending physician to do the following before prescribing an aid-in-dying drug:

   a) Make the initial determination that the requesting adult has the capacity to make medical decisions; and if there are indications of mental disorder, requires referral for a mental health specialist assessment, and prohibits an aid-in-dying drug to be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgement due to a mental disorder;

   b) Make the initial determination that the requesting adult has a terminal disease, has voluntarily made the request for an aid-in-dying drug, is a qualified individual, and to confirm that the individual is making an informed decision by discussing:

      i) Their medical diagnosis;

      ii) The potential risks associated with ingesting the requested aid-in-dying drug;

      iii) The probable result of ingesting the aid-in-dying drug;

      iv) The possibility they may choose to obtain but not take the aid-in-dying drug; and,

      v) The feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control;

   c) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the Act;

   d) Confirm that the individual's request does not arise from coercion or undue influence by another person by discussing with the individual, outside the presence of any other person, except for an interpreter, whether or not the individual is feeling coerced or unduly influenced by another person;

   e) Counsel the individual about the importance of having another person present when ingesting the aid-in-dying drug, not ingesting it in a public place, notifying next of kin of his or her request, but prohibits the denial of the request, if the individual declines or is unable to notify next of kin, participating in a hospice program, and maintaining the aid-in-dying drug in a safe and secure location;

   f) Inform the individual that he or she may withdraw or rescind the request at any time and in any manner;

   g) Offer the individual an opportunity to withdraw or rescind the request before prescribing the aid-in-dying drug;

h) Verify, immediately before writing the prescription that the qualified individual is making an informed decision;

i) Confirm that all requirements are met and all appropriate steps are carried out in accordance with the Act before writing a prescription;

j) Fulfill the required record documentation; and,

k) Complete the attending physician checklist and compliance form, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to DPH. (HSC Section 443.5.)

8) Limits civil or criminal liability solely because a person was present when an individual self-administers the prescribed aid-in-dying drug. Permits a person who is present, without civil or criminal liability, to assist with the individual by preparing the aid-in-dying drug so long as the person does not assist the individual in ingesting the aid-in-dying drug. (HSC Section 443.14.)

9) Limits a health care provider's and health care entity's liability in terms of civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action sanction, or penalty or other liability for participating, including, but not limited to, determining the diagnosis or prognosis of an individual, determining the capacity of an individual for purposes of qualifying for the Act, providing information to an individual regarding the Act, and providing a referral to a physician who participates in the Act. (*Ibid.*)

10) Requires participation in activities authorized pursuant to the Act to be voluntary.

a) Permits a person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized pursuant to the Act.

b) Prohibits a health care provider from being subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate in activities authorized under the Act. (*Ibid.*)

11) Makes knowingly altering or forging a request for an aid-in-dying drug to end an individual's life without their authorization or concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug punishable as a felony if the act is done with the intent or effect of causing the individual's death. (HSC Section 443.17.)

12) Makes knowingly coercing or exerting undue influence on an individual to request, ingest or utilize an aid-in-dying drug for the purpose of ending their life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without their knowledge or consent, punishable as a felony. (*Ibid.*)

13) Imposes civil liability or damages arising from negligent conduct or intentional misconduct in carrying out actions otherwise authorized by the Act by any person, health care provider, or health care entity are not limited. Penalties do not preclude criminal penalties applicable under any law for conduct inconsistent with the provisions of the Act. (*Ibid.*)

14) Requires DPH to collect and review information submitted pursuant to the Act, keep it confidential and protect the privacy of patients, family, and health care providers, and not disclose this information as part of any civil, criminal, administrative, or other proceeding. (*Ibid.*)

15) Requires DPH to post a report from data collected from the attending physician follow-up form, including but not limited to:

    a) The number of people for whom an aid-in-dying prescription was written;

    b) The number of known individuals who died each year for whom aid-in-dying prescriptions were written, and the cause of death of those individuals;

    c) For the period commencing January 1, 2016, to and including the previous year, cumulatively, the total number of aid-in-dying prescriptions written, the number of people who died due to use of aid-in-dying drugs, and the number of those people who died who were enrolled in hospice or other palliative care programs at the time of death;

    d) The number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California;

    e) The number of physicians who wrote prescriptions for aid-in-dying drugs; and,

    f) Of people who died due to using an aid-in-dying drug, demographic percentages organized by age at death, education level, race, sex, type of insurance, including whether or not they had insurance, and underlying illness. (HSC Section 443.17.)

16) Specifies that these provisions will remain in effect only until January 1, 2031, and as of that date is repealed. (HSC Section 443.215.)

FISCAL EFFECT: As currently in print this bill is keyed fiscal.

COMMENTS: This bill, sponsored by Compassion and Choices Network, simply (but not without controversy) repeals the January 1, 2031 sunset date for the End of Life Option Act (Act). According to the author:

> In 2015, the Legislature Passed the End of Life Option Act to give mentally capable, terminally ill Californians the right to request aid-in-dying drugs from their doctor. This allows the person to have an end-of-life experience aligned with their beliefs and values. Since the law went into effect on June 9, 2016, a total of 4,287 people have died following ingestion of aid-in-dying medication.
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> The law is set to sunset on January 1, 2031 and is the only medical-aid-in-dying (MAiD) law in the country that contains a sunset date. The looming sunset can cause undue stress and fear in people diagnosed with a disease that will—in several years—be the cause of their death.
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> Nine years of data show the law is working as intended and MAiD is being safely practiced in California. There have been no reported problems or abuses. SB 403 removes the sunset, making the law permanent. Patients, advocates, medical providers,

and faith leaders who rely on it will no longer need to worry about access to MAiD being removed.

The Right to Die – Constitutional Jurisprudence. Generally, there is a constitutional right of individuals to refuse medical treatment. The U.S. Supreme Court has recognized that a competent adult has a constitutional right to withdraw or withhold life-sustaining treatment that may cause or hasten death. (*Cruzan v. Director, Missouri Dept. of Health* (1990) 497 U.S. 261.) The *Cruzan* Court also recognized that states have an important interest in protecting life and ensuring that a person desired the end of life treatment before it is suspended, and thus can require clear and convincing evidence that a person wanted treatment terminated before it is stopped. Further, the Court held that states can prevent family members from terminating treatment for another as the right belongs to the individual. (*Id.,* at pp. 281, 286.)

In two cases, *Washington v. Glucksberg* (1997) 521 U.S. 702 and *Vacco v. Quill* (1997) 521 U.S. 793, the U.S. Supreme Court upheld facial challenges to state laws that prohibited the aiding of a suicide, drawing a distinction between refusing treatment, even where it might hasten death, and physician-assisted suicide. In those cases, the Court held that the state laws did not violate either a fundamental right under the due process clause (*Glucksberg*) or the equal protection clause (*Vacco*). In other words, the Court found no constitutional right to physician-assisted suicide. At the same time, the decisions left open the possibility that legal protection could be afforded to such laws as a matter of state law. To this end, Justice O'Connor, joined by Justices Ginsberg and Breyer, wrote that while there "is no generalized right to 'commit suicide,'" the Court need not address the "narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her death." (*Glucksberg*, 521 U.S., at p. 737 (J. O'Connor, concurring).)

Similarly, Justice Stevens, joined by Justices Souter, Ginsberg and Breyer, wrote in his separate concurrence to specify that there "is also room for further debate about the limits that the Constitution places on the power of the states to punish the practice." (*Id*. at p. 739 (J. Stevens, concurring).) The Justices recognized that "(t)he *Cruzan* case demonstrated that some state intrusions on the right to decide how death will be encountered are also intolerable" and "(a)lthough there is no absolute right to physician-assisted suicide, *Cruzan* makes it clear that some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs. The liberty interest at stake in a case like this differs from, and is stronger than, both the common-law right to refuse medical treatment and the unbridled interest in deciding whether to live or die. It is an interest in deciding how, rather than whether, a critical threshold shall be crossed." (*Id*. at p. 745.)

It is clear that states have the ability to legislate in this area as long as they do not abridge the constitutionally protected interests recognized by the U.S. Supreme Court.

Background about the Act. The Act, enacted by ABX2 15 (Eggman, Chap. 1, Stats. 2016, 2nd Ex. Sess.), took effect on June 9, 2016. According to data collected by the DPH, as of December 31, 2019, nearly 2,000 terminally ill individuals with six months or less to live received a prescription pursuant to the Act. However, at that time, it also appeared that many eligible patients appeared to have been unable to access the law. A study by Kaiser Permanente Southern California showed that one-third of terminally ill adults who requested to use the Act died before

completing the time-consuming process set forth in then-existing law, including a 15-day waiting period, which often takes weeks or even months to complete.

As a result of SB 380 (Eggman), Chap. 542, Stats. 2021, many of the barriers related to a terminally ill patient's right to obtain an aid-in-dying prescription from their physician under the Act, including by removing the requirement that a patient wait 15 days between requests for assistance, were removed. SB 380 at one point proposed to remove the sunset date from the Act, but ultimately it was amended to extend the sunset until January 1, 2031.

California modeled the Act after Oregon's medical aid-in-dying law, which has been in effect for more than 20 years. In 2019, Oregon updated their law to take into account that many people were dying during the waiting period. Oregon authorized a waiver of the waiting period when the attending physician has determined that the qualified individual will, based upon reasonable medical judgement, die within 15 days of making an initial verbal request for aid-in-dying medication. Recent data from Oregon shows that a significant number of patients (20%), who otherwise would have died during the waiting period, were able to access the state's medical aid-in-dying law as a result of the 2019 revision. (Oregon Health Authority, "Oregon Death with Dignity Act, 2020 Data Summary" (Feb. 2021), available at https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf.) Recently, New Mexico passed End of Life legislation that includes a 48-hour waiting period.

In addition to California, Colorado, Delaware, District of Columbia, Hawai'i, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington have some form of legislation authorizing MAiD. According to polling done in 2023 on behalf of Compassion & Choices, the sponsor of this bill, both national and state polling shows that the vast majority of healthcare professionals and voters across the demographic spectrum support MAiD as an end-of-life care option for terminally ill adults to peacefully end unbearable suffering. The polls also show support for MAiD is rising over time.

Reporting regarding the Act. The Act requires physicians to use forms specified in statute for submitting information to the California Department of Public Health. DPH is responsible for collecting data from these forms to prepare an annual report. Data presented in this report are based on the information from physicians' forms and California death certificates for calendar year 2023.

In 2023, DPH received forms from 1,272 individuals who started the end-of-life option process, by making two verbal requests to their physicians at least 48 hours apart. Of the 1,272 individuals who started the end-of life process, 214 individuals received a prescription in 2023 while the remaining 58 individuals had not yet received a prescription prior to the end of 2023. Out of the 1,214 individuals who started the end-of-life option process in 2023 and received a prescription during 2023, 943 individuals, (77.7%), waited less than 15 days between the two verbal requests. An additional 67 individuals received a prescription during 2023 and began the request process prior to 2023. A total of 337 physicians prescribed 1,281 individuals aid-in-dying drugs. The most common drug category prescribed was a combination of a cardiotonic, opioid, and sedative (98.4%).

Cause of death. Of the 1,281 individuals who were prescribed such drugs in 2023: 835 individuals (65.2%) were reported by their physician to have died following ingestion of aid-in-

dying drugs prescribed under the Act; 170 individuals (13.3%) died from the underlying illness or other causes; and, 276 remaining individuals (21.5%) have an unknown ingestion status.

Demographics. In 2023, of the 884 individuals who died pursuant to the Act 7.2% were under 60 years of age; 76.6% were 60-89 years of age; 16.2% were 90 years of age and older; and 78 years was the median age. Just over 85% were white; 50.1% were male; 93.8% were receiving hospice and/or palliative care; 76.7% had at least some level of college education; and, 80.4% informed their family of their decision to participate in the Act.

This bill would repeal the January 1, 2031 expiration date of the Act, extending the operation of the Act indefinitely. It requires DPH, no later than April 1, 2026, to meet with relevant stakeholders to seek input on the inclusion of additional information already available to DPH, in the annual report on the Act. Commencing with the report due July 1, 2026, it would require DPH to include the additional data in the report, based on the stakeholder input received.

ARGUMENTS IN SUPPORT*:* The bill's sponsor, Compassion & Choices, writes:

> Since the California End of Life Option Act went into effect in 2016, data collected by the California Department of Public Health (CDPH) shows that the law works as intended for those who can access it. This aligns with nearly 30 years of national data on the effectiveness and safety of medical aid-in-dying laws. Since the EOLOA went into effect in 2016, more than 4,000 people have used the law to end their lives peacefully and on their own terms. In 2023, according to the CDPH annual report, over 1,200 Californians received a prescription, and 835 ultimately chose to use it. The majority were enrolled in hospice or palliative care and were 60 years or older. As you know, the law includes numerous safeguards, including a multi-step request process, confirmation of eligibility, and the opportunity for the patient to rescind their request if they change their mind.
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> The law has not only benefited those who have utilized medical aid in dying—it has improved end-of-life care for all terminally ill Californians. Evidence clearly suggests that the passage of medical aid in dying has resulted in:
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> ● improved conversations between physicians and patients,
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> ● better palliative care training, and
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> ● improved enrollment in hospice care.
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> . . . SB 403 offers a clear and compassionate solution: making the EOLOA permanent. This legislation would provide lasting peace of mind to those with terminal diagnoses and give providers and caregivers the clarity they need to continue offering this trusted option to patients.

ARGUMENTS IN OPPOSITION: The Alliance of Catholic Health Care writes:

> In the nine years since the implementation of the EOLOA, not only has there been no substantive review on the compliance of current law, but there has not been full transparency on the data that is collected but is not reported by the California Department of Public Health (CDPH).

Given the sensitive nature of this program, proper oversight is of the utmost importance to the health and wellbeing of Californians. Ensuring the program is operating as intended and there are no troubling aspects of this process for those accessing the program should be a legislative priority.

. . .

The lack of comprehensive reporting has led to significant information concealed from the public and policy makers. Should this data be reported and not just collected, it would provide essential information to patients, physicians, medical professionals, researchers, and Legislators. This information would promote transparency and accountability in complying with this law.

REGISTERED SUPPORT / OPPOSITION:

Support

Compassion & Choices (sponsor)
Choice and Change
Death With Dignity National Center
Delores Huerta Foundation
End of Life Choices California
Full Circle of Living and Dying
Good Grief Doula
LA Patient Advocates
Long Beach Gray Panthers
Social Work Hospice and Palliative Care Network (SWHPN)

Opposition

Alliance of Catholic Health Care, INC.
California Baptist for Biblical Values
California Catholic Conference
California Family Council
California Foundation for Independent Living Centers
LA Luz Project

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